		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003053

Facility Name: Grundy County Home

Address: 1338 Clay Street (Number) Morris (City) 60450 (Zip Code)

County: Grundy

Telephone Number: (815) 942-3255 **Fax #** (815)942-3775

IDPA ID Number: 36-6006567001

Date of Initial License for Current Owners: 11/13/1968

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: T.J. Smith & Associates, P.C. **Telephone Number:** (815) 942-3306 ext 18

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/1999 to 11/30/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Sue Morse
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Carrie E Echols, CPA
(Firm Name & Address) T.J. Smith & Associates, P.C. 116 E Washington St., Suite One Morris, IL 60450
(Telephone) (815) 942-3306 ext 18 Fax # (815) 942-9430

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	143	Intermediate (ICF)	143	52,195	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,195	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	30,113	20,927	61	51,101	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,113	20,927	61	51,101	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.90%

D. How many bed-hold days during this year were paid by Public Aid?
367 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Morris Mobile Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/13/1968

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [X]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: N/A Fiscal Year: 12/1/1999 - 11/30/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	345,461			345,461	48,114	393,575	(1,026)	392,549			1
2	Food Purchase		240,257		240,257	(52,099)	188,158	(19,394)	168,764			2
3	Housekeeping	174,737	101,092		275,829	(75,594)	200,235		200,235			3
4	Laundry	68,759			68,759	16,177	84,936		84,936			4
5	Heat and Other Utilities			88,839	88,839		88,839		88,839			5
6	Maintenance	84,282		79,251	163,533	(4,002)	159,531	228	159,759			6
7	Other (specify):*											7
8	**TOTAL General Services**	673,239	341,349	168,090	1,182,678	(67,404)	1,115,274	(20,192)	1,095,082			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,927,744	81,288	245,649	2,254,681	14,393	2,269,074	(874)	2,268,200			10
10a	Therapy					3,353	3,353		3,353			10a
11	Activities	84,308			84,308	3,278	87,586		87,586			11
12	Social Services	29,814			29,814		29,814		29,814			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*	3,330			3,330		3,330	(909)	2,421			15
16	**TOTAL Health Care and Programs**	2,045,196	81,288	245,649	2,372,133	21,024	2,393,157	(1,783)	2,391,374			16
	C. General Administration											
17	Administrative	118,112			118,112		118,112		118,112			17
18	Directors Fees							4,620	4,620			18
19	Professional Services			13,919	13,919		13,919	4,993	18,912			19
20	Dues, Fees, Subscriptions & Promotions			5,964	5,964		5,964		5,964			20
21	Clerical & General Office Expenses	103,963	1,397	3,285	108,645	8,073	116,718	17,364	134,082			21
22	Employee Benefits & Payroll Taxes			432,848	432,848	52,871	485,719	218,138	703,857			22
23	Inservice Training & Education			3,212	3,212		3,212		3,212			23
24	Travel and Seminar			938	938		938		938			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			138,189	138,189	(12,437)	125,752		125,752			26
27	Other (specify):*			2,124	2,124	(2,127)	(3)		(3)			27
28	**TOTAL General Administration**	222,075	1,397	600,479	823,951	46,380	870,331	245,115	1,115,446			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,940,510	424,034	1,014,218	4,378,762		4,378,762	223,140	4,601,902			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Grundy County Home #0003053 **Report Period Beginning:** 12/01/1999 **Ending:** 11/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			114,837	114,837		114,837		114,837			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,335	13,335		13,335		13,335			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			128,172	128,172		128,172		128,172			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,631	75,631		75,631		75,631			42
43	Other (specify):* PX					1,071	1,071		1,071			43
44	**TOTAL Special Cost Centers**			75,631	75,631	1,071	76,702		76,702			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,940,510	424,034	1,218,021	4,582,565	1,071	4,583,636	223,140	4,806,776			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,697)	2		4
5	Telephone, TV & Radio in Resident Rooms	(100)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(3,010)	10,15,21		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,807)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	245,744		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 245,744		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 232,937		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs			1,071	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,071		47

Grundy County Home

ID# 0003053

Report Period Beginning: 12/01/1999

Ending: 11/30/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Patient Meals	$ (9,697)	2	1
2	Telephone in Resident Rooms	(100)	21	2
3	Sales of supplies to non-patients	(1,026)	1	3
4	Sales of supplies to non-patients	(874)	10	4
5	Sales of supplies to non-patients	(909)	15	5
6	Sales of supplies to non-patients	(201)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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76				76
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78				78
79				79
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(12,807)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,026)	0	0	0	0	0	0	0	0	0	0	(1,026)	1
2	Food Purchase	(19,394)	0	0	0	0	0	0	0	0	0	0	(19,394)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	228	0	0	0	0	0	0	0	0	0	228	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(20,420)	228	0	0	0	0	0	0	0	0	0	(20,192)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(874)	0	0	0	0	0	0	0	0	0	0	(874)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(909)	0	0	0	0	0	0	0	0	0	0	(909)	15
16	**TOTAL Health Care and Programs**	(1,783)	0	0	0	0	0	0	0	0	0	0	(1,783)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	4,620	0	0	0	0	0	0	0	0	0	4,620	18
19	Professional Services	0	4,993	0	0	0	0	0	0	0	0	0	4,993	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(401)	17,765	0	0	0	0	0	0	0	0	0	17,364	21
22	Employee Benefits & Payroll Taxes	0	218,138	0	0	0	0	0	0	0	0	0	218,138	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(401)	245,516	0	0	0	0	0	0	0	0	0	245,115	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,604)	245,744	0	0	0	0	0	0	0	0	0	223,140	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Grundy County Home # 0003053 **Report Period Beginning:** 12/01/1999 **Ending:** 11/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(22,604)	245,744	0	0	0	0	0	0	0	0	0	223,140	45

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		6	Maintenance services	$	County of Grundy	100.00%	$ 228	$ 228	1
2	V		18	Director's fees		County of Grundy	100.00%	4,620	4,620	2
3	V		19	State's Attorney		County of Grundy	100.00%	4,993	4,993	3
4	V		21	Bookkeeping and payroll		County of Grundy	100.00%	6,689	6,689	4
5	V		21	Disbursment services		County of Grundy	100.00%	11,076	11,076	5
6	V		22	Employee retirement		County of Grundy	100.00%	218,138	218,138	6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$ 245,744	$ * 245,744	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 1/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: County of Grundy
Street Address: 1320 Union Street
City / State / Zip Code: Morris, IL 60450
Phone Number: (815) 941-3400
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance services	Hours	2,080	1	$ 14,830	$ 14,830	32	$ 228	1
2	18	Director fees	Direct	73	1	4,620	0	73	4,620	2
3	19	State's Attorney	Hours	2,080	1	129,807	129,807	80	4,993	3
4	21	Bookkeeping and payroll	Hours	1,950	1	20,066	20,066	650	6,689	4
5	21	Disbursement services	Hours	1,950	1	33,228	33,228	650	11,076	5
6	22	Employee retirement system	Direct	1	1	218,138		1	218,138	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 420,689	$ 197,931		$ 245,744	25

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GRUNDY CO PUBLIC BLDG						$	$			$	1
2	COMMISSION	X		NEW ADDITION	various	06/01/1993	400,000	200,000	12/2005	various	13,335	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 400,000	$ 200,000			$ 13,335	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 400,000	$ 200,000			$ 13,335	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,349 B. General Construction Type: Exterior Brick Frame Masonary Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land	930,441	1967	$ 41,097	1
2	Improvements		various	8,595	2
3	TOTALS	930,441		$ 49,692	3

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75		1968	1968	$ 625,474	$ 12,509	50	$ 12,509	$	$ 387,639	4
5	68		1975	1975	936,180	18,724	50	18,724		469,092	5
6			1994	1994	399,074	7,982	50	7,982		47,890	6
7											7
8											8
	Improvement Type**										
9	Landscaping			1968	11,002		20			11,002	9
10	Landscaping			1970	1,599		20			1,599	10
11	Landscaping			1971	618		20			618	11
12	Landscaping			1977	2,635		20			2,635	12
13	Sidewalk and railing			1979	2,002		15			2,002	13
14	Terrace addition			1981	6,422		15			6,422	14
15	Improvements			1981	2,430		15			2,430	15
16	Roof			1982	81,706		15			81,706	16
17	Improvements			1982	4,075		15			4,075	17
18	Downspouts, doors and frames			1983	6,849		15			7,077	18
19	Roof on 1971 addition and entrance canopy			1984	9,989		15			10,243	19
20	Roof on 1971 addition and lighting fixtures			1985	42,247		15			42,247	20
21	Boiler and piping / room tiling			1986	16,787	896	15	896		16,787	21
22	Basement storage room and sprinkler			1987	8,845	591	15	591		8,721	22
23	Linoleum flooring and painting			1989	25,312	1,688	15	1,688		20,950	23
24	Linoleum / ceramic for bath / painting			1990	4,785	319	15	319		3,660	24
25	Asphalt driveway			1991	12,713	848	15	848		8,777	25
26	Painting			1992	3,231	215	15	215		2,151	26
27	Sidewalk			1994	6,750	450	15	450		3,600	27
28	Building improvements			1995	39,394	2,626	15	2,626		18,382	28
29	Windows and landscaping			1996	30,012	2,001	15	2,001		12,506	29
30	Air conditioning unit / windows / nurse call system			1997	322,280	21,485	15	21,485		107,425	30
31	Garage door / soffit repairs / fire alarm panel			1998	17,944	1,196	15	1,196		4,784	31
32	Dining room renovation / generator upgrade			1999	6,433	429	15	429		858	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,626,788	$ 71,959		$ 71,959	$	$ 1,285,278	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 235,430	$ 31,079	$ 31,079	$	5,10,15	$ 164,547	37
38	Current Year Purchases	23,808	4,423	4,423		5,10,15	4,423	38
39	Fully Depreciated Assets	522,009					522,009	39
40								40
41	TOTALS	$ 781,247	$ 35,502	$ 35,502	$		$ 690,979	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Transport residents	Dodge 1996 Van	1997	$ 12,007	$ 3,001	$ 3,001	$		$ 12,007	42
43	Transport residents	Ford 1994 Van	1998	17,500	4,375	4,375			13,125	43
44										44
45										45
46	TOTALS			$ 29,507	$ 7,376	$ 7,376	$		$ 25,132	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,487,234	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 114,837	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 114,837	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,001,389	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs							4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	line 12 col 1	2144	hrs	29,814				2,144	29,814	10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 29,814		$	$	2,144	$ 29,814	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 292,107	$	1
2	Cash-Patient Deposits	3,363		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 295,470	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	49,692		13
14	Buildings, at Historical Cost	2,626,788		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	810,754		16
17	Accumulated Depreciation (book methods)	(2,001,389)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,485,845	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,781,315	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Patient funds reserve**	3,363		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,363	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	200,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 200,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 203,363	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,577,952	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,781,315	$	48

***(See instructions.)**

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,817,218	1
2	Restatements (describe):		2
3	**less reclassification of long term debt out of equity**	(235,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,582,218	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(4,266)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (4,266)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,577,952	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,578,299	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,578,299	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,578,299	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,182,678	31
32	Health Care	2,372,133	32
33	General Administration	823,951	33
	B. Capital Expense		
34	Ownership	128,172	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	75,631	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,582,565	40
41	**Income before Income Taxes (line 30 minus line 40)****	(4,266)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (4,266)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,191	2,959	$ 59,998	$ 20.28	1
2	Assistant Director of Nursing	1,584	1,680	28,454	16.94	2
3	Registered Nurses	25,923	30,223	535,127	17.71	3
4	Licensed Practical Nurses	11,756	13,566	204,421	15.07	4
5	Nurse Aides & Orderlies	101,866	115,416	1,099,744	9.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,760	2,160	24,493	11.34	9
10	Activity Assistants	5,327	6,285	59,815	9.52	10
11	Social Service Workers	1,910	2,144	29,814	13.91	11
12	Dietician					12
13	Food Service Supervisor	1,875	2,175	30,386	13.97	13
14	Head Cook	7,967	9,234	116,515	12.62	14
15	Cook Helpers/Assistants	21,392	23,960	198,560	8.29	15
16	Dishwashers					16
17	Maintenance Workers	5,669	6,676	84,282	12.62	17
18	Housekeepers	16,108	18,533	174,737	9.43	18
19	Laundry	6,921	7,946	68,759	8.65	19
20	Administrator	1,796	2,080	55,947	26.90	20
21	Assistant Administrator	1,544	2,038	37,063	18.19	21
22	Other Administrative					22
23	Office Manager	1,909	2,149	25,102	11.68	23
24	Clerical	8,230	9,384	103,963	11.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) volunteer coord	371	405	3,330	8.22	33
34	TOTAL (lines 1 - 33)	226,099	259,013	$ 2,940,510 *	$ 11.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 3,420	line 10 col 5	35
36	Medical Director		4,800	line 10 col 5	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,716	line 10 col 5	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,622	line 10 col 5	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Rehabilitation Consultant		3,353	line 10a col 5	47
48					48
49	TOTAL (lines 35 - 48)		$ 15,911		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue Morse	Administrator	n/a	$ 55,947
Steve Brooks	Asst Admin	n/a	37,063
Jane Farcus	Office Mngr	n/a	25,015
DeLores Herman	Office Mngr	n/a	87
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 118,112

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
T.J. Smith & Associates, P.C.	long care report	$ 4,000
Aurand, Bowers, & Associates	labor negotiations	9,545
Canna & Canna Ltd	legal services	374
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 13,919

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker's Compensation Insurance	13,422
Unemployment Compensation Insurance	0
FICA taxes	218,138
Employee health insurance	260,622
Employee meals	52,998
Illinois Municipal Retirement Fund (IMRF)	158,677
TOTAL (agree to Schedule V, line 22, col.8)	$ 703,857

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,403
Health Care Worker Background Check	
(Indicate # of checks performed)	
County Nursing Home Association	1,430
Publications and subscriptions	1,131
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,964

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Misc travel & seminar exp for administration	938
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 938

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Grundy County Home # 0003053 Report Period Beginning: 12/01/1999 Ending: 11/30/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Grundy County Home # 0003053 **Report Period Beginning:** 12/01/1999 **Ending:** 11/30/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **County Nursing Home Association $1,430**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **25,944** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **75,631**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **52,998** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **9,697**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **N/A** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **T.J. Smith & Associates, P.C.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain. **Audit is part of Grundy County**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.